STATE OF MICHIGAN

DEPARTMENT OF LABOR & ECONOMIC GROWTH

OFFICE OF FINANCIAL AND INSURANCE SERVICES

Before the Commissioner of Financial and Insurance Services

In the matter of

XXXXXX XXXXXX
Petitioner **File No. 88006-001**

v

Humana Insurance Company
Respondent
_____/

Issued and entered
this 26th day of March 2008
by Ken Ross
Commissioner

ORDER

I
PROCEDURAL BACKGROUND

On February 21, 2008, XXXXX XXXXX (Petitioner) filed two requests for external review with the Commissioner of Financial and Insurance Services under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.* The Commissioner accepted the requests on February 27, 2008. Since both requests concern the same service, they have been combined in this external review.

The Commissioner notified Humana Insurance Company (Humana) of the external review and requested the information used in making its adverse determination.

The issue here can be decided by applying the terms of the Petitioner's certificate of insurance (the certificate), the contract that defines his health care benefits. The Commissioner reviews contractual issues pursuant to MCL 550.1911(7). This matter does not require a medical opinion from an independent review organization.

II
FACTUAL BACKGROUND

The Petitioner is covered by a group medical policy underwritten by Humana that was effective on January 1, 2006.

On July 2, 2007, the Petitioner had outpatient eye surgery. The physician performing the surgery was in Humana's network of providers but the facility where the surgery was performed, XXXXX Hospital, was not. Humana processed the claims for the facility charges, including a certified register nurse anesthetist (CRNA), as out-of-network benefits and as a result the Petitioner was responsible for $5,684.00 in charges.

The Petitioner appealed Humana's decision. After he completed Humana's internal grievance process, Humana issued a final adverse determination dated December 20, 2007, upholding its decision on the out-of-network claims.

III
ISSUE

Did Humana correctly process the Petitioner's non-network facility claims for his surgery on July 2, 2007?

IV
ANALYSIS

These terms of the Petitioner's certificate apply in this case:

- The Petitioner has an individual annual non-network deductible of $3,000.00; that is, he is responsible for the first $3,000.00 of covered expenses from non-network providers (page 10);
- Non-network hospital outpatient surgical services are paid at 70% after a $50.00 per visit copayment and the non-network provider deductible (page 15); and
- Non-network health care practitioner outpatient services (e.g., the CRNA) are paid at 70% after the non-network provider deductible (page 15).

The certificate (page 4) also explains how Humana pays when services are received from non-network providers:

> **Your choice of providers affects your benefits**
>
> * * *
>
> If *you* receive services from a *non-network provider*, *we* will pay benefits at a lower percentage and *you* will pay a larger share of the costs. Since *non-network providers* have not agreed to accept discounted or negotiated fees, they may bill *you* for charges in excess of the *maximum allowable fee*. *You* are responsible for charges in excess of the *maximum allowable fee* in addition to any applicable *deductible*, *coinsurance* and/or *copayment*. Any amount *you* pay to the provider in excess of *your coinsurance* or *copayment* will not apply to your *out-of-pocket limit* or *deductible*. [Italics and underlining in original]

The services the Petitioner received from the non-network facility and non-network CRNA are shown in this table:

A	B	C	D	E	F	G
Service	**Provider Charge**	**Humana's Maximum Allowable Fee**	**Amount Not Covered (B – C)**	**Applied to Deductible**	**Copayment**	**Petitioner's Responsibility (D+E+F)**
Operating Room	2,592.00	792.63	1,799.37	742.63	$ 50.00	2,592.00
Supplies	$ 532.00	$ 162.69	$ 369.31	162.69		$ 532.00
Laboratory	564.00	172.47	391.53	172.47		564.00
Anesthesia	856.00	261.76	594.24	261.76		856.00
Observation Room	732.00	223.85	508.15	223.85		732.00
CRNA	408.00	204.00	204.00	204.00		408.00
Totals	$5,684.00	$ 1,817.40	$ 3,866.60	1,767.40	$ 50.00	$ 5,684.00

Under the terms of the certificate, when services are received from a non-network provider, Humana's payment (as explained above) is based on its maximum allowable fee for the service (column C), not the provider's charge, and the Petitioner is responsible for the difference between the provider's charge and Humana's maximum allowable fee (column D).

For the hospital facility services, the Petitioner was required to pay a $50.00 copayment and then Humana applied the balance of its maximum allowable fee for each service (column E) to the Petitioner's $3,000.00 annual non-network deductible. For the CRNA service, Humana also applied its maximum allowable fee to the annual non-network deductible. Since the total applied to the non-network deductible was only $1,767.40, the Petitioner had not satisfied the

$3,000.00 deductible and Humana was therefore not required to share any of the cost for the Petitioner's eye surgery from non-network providers.

It appears that the Petitioner assumed that Humana's 70% payment would be based on the provider's charge. However, the certificate explains (page 96) how Humana establishes its maximum allowable fee for any given covered service:

> ***Maximum allowable fee*** for a covered expense is the lesser of:
>
> - The fee charged by the provider for the service;
> - The fee that has been negotiated with the provider whether directly or through one or more intermediaries or shared savings contracts for the service;
> - The fee established by us by comparing rates from one or more regional or national databases or schedules for the same or similar services from a geographical area determined by us;
> - The fee based upon rates negotiated by us or other payors with one or more network providers in a geographic area determined by us for the same or similar services;
> - The fee based upon the provider's cost for providing the same or similar services as reported by such provider in its most recent publicly available Medicare cost report submitted to the Centers for Medicare and Medicaid Services (CMS) annually; or
> - The fee based on a percentage determined by us of the fee Medicare allows for the same or similar services provided in the same geographic area.
>
> **Note:** The bill you receive for services from non-network providers may be significantly higher than the maximum allowable fee. In addition to deductibles, copayments and coinsurance, you are responsible for the difference between the maximum allowable fee and the amount the provider bills you for the services. Any amount you pay to the provider in excess of the maximum allowable fee will not apply to your out-of-pocket limit or deductible.

Humana explained in its final adverse determination to the Petitioner that it based its maximum allowable fee for XXXXX Hospital on data from the Centers for Medicare and Medicaid Services.

The Commissioner finds that Humana has correctly processed the claims for the non-network services the Petitioner received during his eye surgery on July 2, 2007.

V
ORDER

The Commissioner upholds Humana Insurance Company's December 20, 2007, final adverse determination.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than sixty days from the date of this Order in the circuit court for the county where the covered person resides or in the Circuit Court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of the Office of Financial and Insurance Services, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.